3 Service Coordination Guidelines

3.1 General Policy

3.1.1 Definition

Service coordination services are delivered by qualified providers to assist Medicaid participants who are unable, or have limited ability, to gain access to, coordinate, or maintain services on their own or through other means. See *IDAPA 16.03.10.720 Service Coordination through 736 Service Coordination – Provider Reimbursement,* for rules regarding Service Coordination.

- Service coordination services are limited to the following target populations:
  - o Adults with Developmental Disabilities.
  - o Adults with Severe and Persistent Mental Illness.
  - o Individuals who are receiving personal care services or who are receiving Home and Community Based Services for the aged and physically disabled.
  - o Children through the month of their 21st birthday under EPSDT *(IDAPA 16.03.10.726).*

  Note: Service Coordination for participants enrolled in the Medicaid Basic Plan is limited to diagnostic and evaluation procedures only. Participants enrolled in the Medicaid Enhanced Plan are eligible for additional service coordination services.

See *Section 3.2 Service Coordination Eligibility,* for the eligibility requirements for these target populations.

- Service coordination is a brokerage model of case management and does not include the provision of direct services.
- Service coordination consists of the following functions:
  - o Assessment. Evaluation of the participant's ability to gain access to needed services; coordinate or maintain those services; and identify services and supports the participant needs to maintain their highest level of independence in the community. (For assessment requirements see *IDAPA 16.03.10.727.03.a-d*).
  - o Plan development. Except for service coordination for participants with a mental illness, a written service plan must be developed within 60 days after the participant chooses a service coordination agency. The plan for participants with mental illness must be developed within 30 days after the participant chooses a service coordination agency. The plan must be updated at least annually. The plan must address the service coordination needs of the participant as identified in the assessment. (For service plan content requirements see *IDAPA 16.03.10.728.02.a-d*).
  - o Linking the participant to needed services. Finding, arranging and assisting the participant to maintain services, supports, and community resources identified on the service plan; and advocating for the unmet needs of the participant; and encouraging independence.
  - o Monitoring and coordination of services. Assisting the participant and family/guardian to coordinate and retain services, assure the consistency and non-duplication between services; and assure participant satisfaction and making adjustments in the plan when necessary.
- Service coordinators must have contact with the participant, legal guardian or provider who can verify the participant's well being and whether services are being provided according to the written plan at least every 30 days. The frequency, mode of contact, and person being contacted must be identified in the plan. Mental health service coordinators must have face-to-face contact with each participant every month. Developmental disability and PCS service coordinators must have face-to-face contact with each participant at least every 90 days. EPSDT service coordinators must have face-to-face contact with the child and the child's family at least every 90 days.
- Service coordinators do not have to be available on a 24 hour basis, but must include on the written plan what the participant, families, and providers should do in an emergency situation.

3.1.2 Payment

Medicaid reimburses service coordination services on a fee-for-service basis or a flat monthly rate. Usual and customary fees are paid up to the Medicaid maximum allowance.

- Service Coordination services to adults with mental illness or who are receiving personal care or waiver services are reimbursed on a fee-for-service basis.
- Service Coordination services to adults with a developmental disability or for children under the EPSDT program are reimbursed through a flat monthly rate.

3.1.3 Non-Covered Services

- Service Coordination does not include the provision of direct service.
- Medicaid does not pay for service coordination activities that duplicate services or payments for the same purposes.
- Medicaid does not pay for ongoing service coordination delivered prior to the completion of the service coordination plan. Services provided to a group of participants are not covered.
- Medicaid does not pay for service coordination when the participant is incarcerated.
- Medicaid does not pay for service coordination for missed appointments, attempted contacts, travel to provide the service, leaving messages, scheduling appointments with the Medicaid coordinator, transporting participants, or documenting services.

3.1.4 Service Limitations

Service Coordination services for different populations have different limitations. They are:

- Service Coordination for adults with mental illness is limited to five hours per month.
- Service Coordination for individuals receiving personal care services or aged/disabled waiver services is limited to 8 hours per month as prior authorized by DHW.

Medicaid does not pay for service coordination services provided to participants who are inpatients in NF, ICF/MR, or hospitals, except under the following conditions:

- Service coordination services rendered on the admit or discharge date from a long-term care facility or hospital, as long as the participant is not yet admitted or has been discharged at the time of the service delivery.
- Service coordination services may be rendered during the last 30 days of an inpatient stay or when the inpatient stay is not expected to last longer than 30 days. Service coordination services cannot duplicate services that are included in the responsibilities of the facility.

The total caseload of a service coordinator must not exceed a number over which the service coordinator can assure quality service delivery and participant satisfaction.

Note: Failure to adequately document service delivery may result in the recoupment of money paid for such services.

3.1.5 Payment Limitations

Participants are only eligible for one type of service coordination. If they qualify for more than one type, the participant must choose one.

Service coordination payment must not duplicate payment made to public or private sector entities under other program authorities for this same purpose.

Payment for Service Coordination is only allowed for the following services:

- Face to face contact between the service coordinator and the participant, participant's family members, legal representative, primary caregivers, providers, or other interested persons.

- Telephone contact between the service coordinator and the participant, participant's service providers, family members, primary care givers, legal representative, or other interested persons.
- Paperwork that is associated with obtaining needed services such as food stamps, energy assistance, emergency housing, or legal services.

Payment for ongoing service coordination will not be made prior to the completion of the assessment and service plan.

For service coordination, paid as 15 minute time increments, providers will not be reimbursed for more than one contact during a single 15 minute period.

Failure to provide services for which reimbursement has been received is cause for recoupment of payment, sanctions, or both.

3.1.6 Determining How to Bill Units for 15 Minute Timed Codes

Several CPT codes used for evaluations, therapy modalities, procedures, and collateral contacts specify that 1 unit equals 15 minutes. Provider's bill procedure codes for services delivered using CPT codes and the appropriate number of units of service. For any single CPT code, providers bill a single 15 minute unit for treatment greater than or equal to 8 minutes. Two units should be billed when the interaction with the participant or collateral contact is greater than or equal to 23 minutes to less than 38 minutes. Time intervals for larger numbers of units are as follows:

3 units	**≥ 38 minutes to < 53 minutes**
4 units	**≥ 53 minutes to < 68 minutes**
5 units	**≥ 68 minutes to < 83 minutes**
6 units	**≥ 83 minutes to < 98 minutes**
7 units	**≥ 98 minutes to <113 minutes**
8 units	**≥ 113 minutes to < 128 minutes**

The pattern remains the same for treatment times in excess of 2 hours. Providers should not bill for services performed for < 8 minutes. The expectation (based on work values for these codes) is that a provider's time for each unit will average 15 minutes in length. If a provider has a practice of billing less than 15 minutes for a unit, these situations should be highlighted for review. The above schedule of times is intended to provide assistance in rounding time into 15 minute increments for billing purposes. It does not imply that any minute until the 8th should be excluded from the total count as the timing of active treatment counted includes all time. The beginning and ending time of the treatment must be recorded in the participant's medical record with the note describing the treatment. **(For additional guidance please consult *CMS Program Memorandum Transmittal AB-00-14*.)**

3.1.7 Participant Choice

All Medicaid participants have free choice in the decision to receive or not receive service coordination services. Documentation indicating the participant's choice must be kept with their record.

3.1.8 Record Requirements

The following documentation must be maintained by the provider as required in *IDAPA 6.03.10.728.03.a-j Service Coordination – Procedural Requirements*:

- Name of the participant.
- Name of agency and person providing service.
- Date, time and POS.
- Documentation of eligibility.
- A copy of the assessment and service plan signed by participant or legal representative and the plan developer. Mental health service coordination plans must also be signed by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law (or as indicated in each specific program rule). The service coordinator must also document that a copy of

the plan was given to the participant or legal representative. Plan must be updated and authorized when required, but at least annually.

- Description of the service provided signed by the person who delivered the service.
- Documented review of progress toward each service plan goal.
- Assessment of the participant's need for targeted service coordination and other services as the participant's needs change.
- Informed consent.
- Documentation of the participant's, family's, or guardian's satisfaction with service.
- For adults with mental Illness, documentation to support authorization of crisis assistance beyond the monthly limitation. See *IDAPA 16.03.10.728.03.j Crisis Assistance Documentation for Adults With Severe and Persistent Mental Illness*, for detailed description of the content of the documentation.

3.1.9 Prior Authorization (PA)

Some service coordination services require prior authorization. When a service is prior authorized, the approval is valid for one year from the authorized date unless otherwise indicated.

For HC participants, PA will be denied if the requesting provider is not the primary care provider (PCP) or a referral has not been obtained. An HC referral is not required for service coordination services for individuals receiving personal care or A&D waiver services.

For more information on prior authorization, see *Section 2.3.2 Medicaid Prior Authorization (PA)*.

Service coordination for adults with mental illness does not require PA for the first five hours of service each month. Providers must document the need for service coordination in the participant's records. See *Section 3.4.2 Crisis Assistance for Adults with Severe and Persistent Mental Illness*.

Service coordination for individuals receiving PCS or A&D waiver services requires two PAs from RMS. They are as follows:

- The participant must be approved by RMS for service coordination. RMS will authorize the assessment and service plan development.
- Based on the Individual Community Support Plan (ICSP), RMS authorizes hours of ongoing service coordination.

Service coordination for adults with developmental disabilities requires PA in accordance with *IDAPA 16.03.10.507 Behavioral Health Prior Authorization (PA)* through *515 Behavioral Health – Quality Assurance And Improvement.* The service coordinator must update the approved plan for service coordination at least annually.

Service coordination for children under EPSDT requires PA and a service plan completed by DHW or its designee for the initial service plan prior to delivery of service coordination services. The service coordinator must review and update the approved Service Plan for service coordination at least annually. The Regional Children's DD program must approve the plan for continued PA.

3.1.10 Procedure Codes

All service coordination services must be billed using the appropriate HCPCS.

Please note that some codes may require the use of a designated modifier code when billing appropriate services codes.

Service	HCPCS	Description
Mental Health Service Coordination Assessment (TCM/MI)	**H0031**	Mental Health Assessment, by Non-Physician Includes annual assessment, interviewing and treatment plan building 1 Unit = 15 minutes Limited to 24 units for the initial assessment and plan.
Mental Health Service Coordination Ongoing (TCM/MI)	**T1017**	Targeted Service Coordination, each 15 minutes (ongoing service coordination). Limited to 5 hours of non-crisis ongoing service coordination monthly and 3 hours of crisis ongoing service coordination.
Mental Health Service Coordination Crisis	**H2011**	Three hours of crisis assistance per month may be provided without authorization by DHW. The DHW may authorize additional crisis service coordination services beyond the three hour limit if a participant still has severe or prolonged crisis service coordination needs that meet all of the criteria described in, Section 3.4.2 Crisis Assistance for Adults with Severe and Persistent Mental Illness. 1 Unit = 15 minutes
Personal Care Assessment and ICSP Development (PCS)	**G9001** Use Modifier **U2** when Individual is on A&D waiver	Coordinated Care Fee, Initial Rate (Assessment and ICSP). This is a one-time rate. Requires PA by RMS.
Personal Care Service Coordination Ongoing (PCS)	**G9002** Use Modifier **U2** when individual is on A&D waiver	Coordinated Care Fee, Maintenance Rate Ongoing and emergency PCS service coordination. Indicate the total number of 15-minute units billed. Requires PA by RMS.
DD Service Coordination, Initial (TSC)	**G9001**	Coordinated Care Fee, Initial Rate (Initial service coordination) Flat monthly rate for the first six calendar months. 1 Unit = 1 month initial service coordination
DD Service Coordination, Ongoing (TSC)	**G9002**	Coordinated Care Fee, Maintenance Rate (Ongoing service coordination) Flat monthly rate for the calendar months after the initial six months. 1 Unit = 1 month ongoing service coordination

Service	HCPCS	Description
EPSDT Service Coordination Initial (ESC)	**G9001** Use Modifier **EP**	Coordinated Care Fee, Initial Rate (Initial EPSDT service coordination). Flat monthly rate for the first six calendar months. At least one contact with the participant, legal guardian or a provider who can verify the participant's well being and whether services are being provided according to the written plan must occur within each month billed for. 1 Unit = 1 month
EPSDT Service Coordination, Ongoing (ESC)	**G9002** Use Modifier **EP**	Coordinated Care Fee, Maintenance Rate (Ongoing EPSDT service coordination) Flat monthly rate for the calendar months after the initial six months. At least one contact with the participant, legal guardian or a provider who can verify the participant's well being and whether services are being provided according to the written plan must occur within each month billed for. 1 Unit = 1 month
EPSDT , Crisis Assistance (ESC)	**G9003**	Coordinated Care Fee, Risk Adjusted High, Initial (Emergency service coordination). PA is required by RMS. 1 Unit = 15 minutes

3.1.11 Place of Service (POS) Codes

Enter the appropriate numeric code in the POS field on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

03 School

11 Office

12 Home

22 Outpatient hospital

23 Emergency Room: hospital

31 Skilled nursing facility

32 Nursing facility

33 Custodial care facility

53 Community mental health center

54 Intermediate care facility/mentally retarded (ICF/MR)

71 Public health clinic

99 Other unlisted facility

3.1.12 Diagnosis Codes

Enter the appropriate primary ICD-9-CM diagnosis code for the participant's condition in field **21** on the CMS-1500 claim form, or in the appropriate field of the electronic claim form.

Exception: Use diagnosis code **V604** - No Other Household Member Able to Render Care, as the primary diagnosis code for personal care case management.

3.2 Service Coordination Eligibility

Participants identified below who do not receive hospice services or live in hospitals, nursing facilities, or intermediate care facilities for the mentally retarded, are eligible for service coordination:

Adults with a Developmental Disability as defined in *Section 66-402 of Idaho Code* and *IDAPA 16.03.10.501 Developmental Disability Determination Standards – Eligibility* through *503 Developmental Disability Determination – Test Instruments,* are eligible for service coordination if they:

- Are 18 years of age or older, or adolescents 15 - 18 years of age who are authorized to receive services through the Idaho State School and Hospital (ISSH) waiver; and
- Are diagnosed with a developmental disability; and
- Have impairments that result in substantial functional limitations in three or more of the following areas of major life activity: self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency; and
- Need a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated.
- Require and choose assistance to adequately access services and supports necessary to maintain their independence in the community.

Individuals who receive personal assistance services are eligible for service coordination if they:

- Are adults or children who have been approved to receive state plan personal care services; or
- Are adults who have been approved to receive aged and disabled home and community based waiver services; and
- Require and choose assistance to access services and supports necessary to maintain their independence in the community.

Adults with severe and persistent mental illness are eligible for service coordination if they:

- Are 18 years of age or older; and
- Have a severe and persistent mental illness with a diagnosis identified in *IDAPA 16.03.10.725.02.a-b.*
- Have functional limitations due to a mental illness identified in *16.03.10.725.03.a-h.*
- Have a history of using high cost medical services including hospital services with frequent exacerbations of mental illness.

Children up to the age of 21 are eligible for service coordination if they:

- Are between birth and the month of their 21 birthday; and
- Are identified by a physician or other practitioner of the healing arts in an EPSDT screen (Well-child Check) as needing service coordination services; and
- Have one of the following:
    - Developmental delay or disability.
    - Special health care needs requiring medical and multidisciplinary habilitation or rehabilitation services to prevent or minimize a disability.
    - Severe emotional disorder under DSM-IV-TR with an expected duration of at least one year (*IDAPA 16.03.10.726.02.c*); and
- Have one or more of the following problems associated with their diagnosis:
    - The condition has resulted in a level of functioning below normal age level in one or more life areas such as school, family or community.

- They are at risk of placement in a more restrictive environment or they are returning from an out of home placement as a result of the condition.
- There is danger to their health or safety or the parents are unable to meet their needs.
- Further complications may occur as a result of the condition without provision of service coordination services.
- They require multiple service providers and treatments.

Note: Service coordination for participants enrolled in the Medicaid Basic Plan is limited to diagnostic and evaluation procedures only**.** Participants enrolled in the Medicaid Enhanced Plan are eligible for additional service coordination services.

3.3 Provider Qualifications

3.3.1 Service Coordinators

All service coordinators must be employees or contractors of an agency that has a valid provider agreement with DHW.

- Agencies that hire employees must meet all requirements for an agency listed in the general provider agreement including worker's compensation and general liability insurance.
- An agency includes a minimum of at least a supervisor and a service coordinator.
- Agencies may not provide both service coordination and direct services to the same Medicaid participant except for: Service coordination for children under EPSDT and service coordination for adults with severe and persistent mental illness.

All service coordinators must have a minimum of a bachelor's degree in a human services field from a nationally accredited university or college; or be a licensed professional nurse (RN).

- A human services field is a particular area of academic study in health, social services, education, behavioral science or counseling.

All service coordinators must have a least 12 months experience working with the population they will be serving or be supervised by a qualified service coordinator.

Work experience must be at least 20 hours per week.

All service coordinators must pass DHWs criminal history check in *IDAPA 16.05.06 Criminal History and Background Checks*.

3.3.2 Paraprofessionals

Under the supervision of a qualified service coordinator, paraprofessionals may be used to assist in the implementation of a service coordination plan except for plans of participants with a mental illness.

- Paraprofessionals may not conduct the assessments or develop service coordination plans.
- Paraprofessionals must be able to read and write at a level equal with the paperwork and forms involved in the provision of service.
- Paraprofessionals must pass DHWs criminal history check as described in *IDAPA 16.05.06 Criminal History and Background Checks.*

3.3.3 Supervision of Service Coordination

Service coordination agencies must provide supervision to qualified service coordinators and paraprofessionals employed or under contract with the agency. Agency supervisors must have the following qualifications:

- Be an employee or contractor of an agency that has a valid provider agreement with DHW

  and

- Master's degree in a human services field (see *Section 3.3.1 Service Coordination*) and one year's experience with the population for whom they will be supervising services;

  For supervisors of service coordination for participants with mental illness, this experience must be in a mental health service setting

  or

- Bachelors degree in a human services field (see *Section 3.3.1 Service Coordination*) or R.N. degree and two years' experience with the population for whom they will be supervising services

  For supervisors of service coordination for participants with mental illness, this experience must be in a mental health service setting

and

- Must pass DHWs criminal history check in *IDAPA 16.05.06 Criminal History and Background Checks.*

3.4 Crisis Service Coordination

Crisis service coordination services are linking, coordinating and advocacy services provided to assist a participant to access emergency community resources in order to resolve a crisis. Crisis service coordination does not include crisis counseling, transportation to emergency service providers, or direct skill-building services.

Crisis assistance, including services to prevent hospitalization or incarceration may be provided before the completion of an assessment and development of a plan of service.

Note: Service coordination for participants enrolled in the Medicaid Basic Plan is limited to diagnostic and evaluation procedures only**.** Participants enrolled in the Medicaid Enhanced Plan are eligible for additional service coordination services.

3.4.1 Crisis Assistance for Adults with a Developmental Disability

Crisis assistance for adults with a developmental disability may be authorized under community crisis supports as found in *IDAPA 16.03.10.511.13,* if at least four hours of service coordination has already been provided that month.

3.4.2 Crisis Assistance for Adults with Severe and Persistent Mental Illness

Three hours of crisis assistance per month may be provided without authorization by DHW or its designee. DHW may authorize additional crisis service coordination services beyond the three hour limit if a participant still has severe or prolonged crisis service coordination needs that meet all of the following criteria:

- The service participant is at imminent risk (within 14 days) of hospitalization or institutionalization, including jail or nursing home.
- The service participant is experiencing symptoms of psychiatric decompensation.
- The service participant has already received the maximum number of monthly hours of ongoing service coordination and crisis service coordination services.
- No other crisis assistance services are available to the participant under other Medicaid mental health option services, including Psychosocial Rehabilitation Services (PSR).

Process to request mental illness crisis hours:

Step 1 Complete Request for Additional Service Coordination Hours form.

Step 2 Email or fax to Mental Health and Substance Abuse Unit at:
carlins@dhw.idaho.gov
(208) 364-1903

Step 3 Attach Request for Additional Service Coordination Hours, service coordination assessment and treatment plan, and applicable notes.

3.4.3 Crisis Assistance for Individuals Who Receive Personal Assistance Services/A&D Waiver Services

Additional hours for crisis assistance may be authorized for individuals who receive personal assistance services, if at least eight hours of service coordination has already been provided in the month.

3.4.4 Crisis Assistance for Children Receiving EPSDT Service Coordination

Additional crisis hours may be authorized for service coordination for children receiving EPSDT service coordination, if at least four hours of service coordination has already been provided in the month.

3.5 Claim Billing

3.5.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

Note: All claims must be received within 12 months (365 days) of the date of service.

3.5.2 Electronic Claims

For PES software billing questions, consult the *Provider Electronic Solutions (PES) Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software. See *Section 2.2.1 Electronic Claims Submission,* for more information.

3.5.2.1 Guidelines for Electronic Claims

Provider Number: In compliance with HIPAA and the National Provider Identifier (NPI) initiative beginning May 24, 2008, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

Detail lines: Idaho Medicaid allows up to 50 detail lines for electronic HIPAA 837 Professional transactions.

Referral number: A referral number is required on an electronic HIPAA 837 Professional transaction when a participant is referred by another provider. Use the referring provider's 9-digit Medicaid provider number, unless the participant is a HC participant. For HC participants, enter the provider's 9-digit HC referral number.

Prior authorization (PA) numbers: Idaho Medicaid allows more than one PA number on an electronic HIPAA 837 Professional transaction. A PA number can be entered at the header or at each detail of the transaction.

Modifiers: Up to four modifiers per detail are allowed on an electronic HIPAA 837 Professional transaction.

Diagnosis codes: Idaho Medicaid allows up to eight diagnosis codes on an electronic HIPAA 837 Professional transaction.

National Drug Code (NDC) information with HCPCS and CPT codes: A corresponding NDC is required on the claim detail when medications billed with HCPCS codes are submitted. See *Section 3.18.6.3* of the *Physician Guidelines,* for more information.

Electronic crossovers: Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

3.5.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2006 is entered as 07042006

3.5.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean; use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MMDDCCYY) format; note that in field **24A** (From and To Dates of Service) there are smaller spaces for entering the century and year; Refer to specific instructions for field **24A.**
- You can bill with a date span (From and To Dates of Service) only if the service was provided every consecutive day within the span.
- A maximum of six line items per claim can be accepted; if the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements; total each claim separately.
- Be sure to sign the form in the correct field; claims will be returned that are not signed unless EDS has a signature on file.
- Do not use staples or paperclips for attachments; stack the attachments behind the claim.
- Do not fold the claim form(s); mail flat in a large envelope (recommend 9 x 12).
- Only one PA number is allowed for paper claims.
- When billing medications with HCPCS/CPT codes, an NDC Detail Attachment must be filled out and sent with the claim.

3.5.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
PO Box 23
Boise, ID 83707

3.5.3.3 Completing Specific Fields of CMS-1500

Consult the Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid Program are shown on the following table. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Note: Claim information should not be entered in the shaded areas of each detail unless specific instructions have been given to do so.

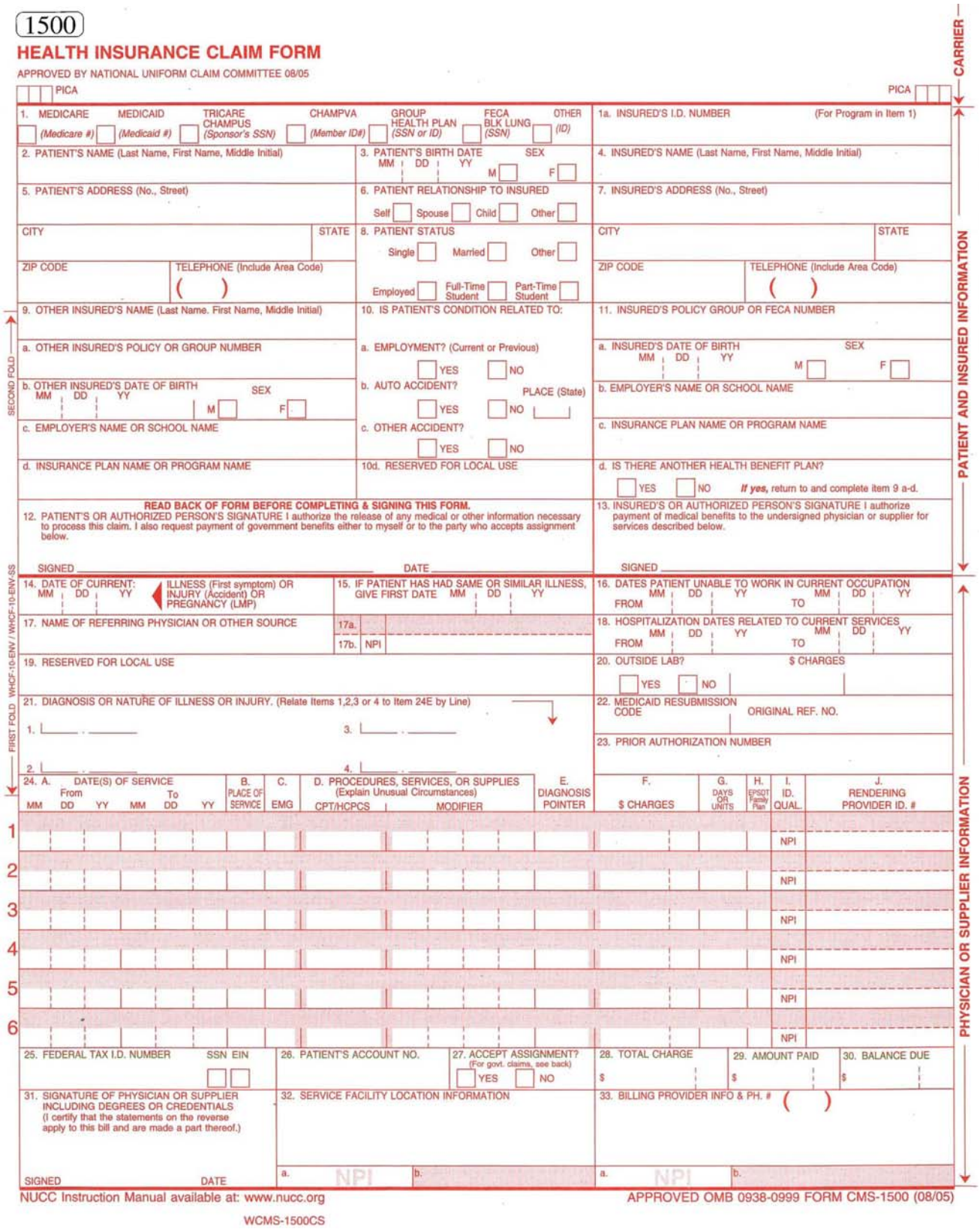
Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the participant's 7-digit Medicaid identification (MID) number exactly as it appears on the MAID card.

Field	Field Name	Use	Directions
2	Patient's Name	Required	Enter the participant's name exactly as it is spelled on the MAID card. Be sure to enter the last name first, followed by the first name and middle initial.
9a	Other Insured's Policy or Group Number	Required if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required if applicable	Required if field **11d** is marked yes.
9d	Insurance Plan Name or Program Name	Required if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate Yes or No, if this condition is related to the participant's employment.
10b	Auto Accident?	Required	Indicate Yes or No, if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate Yes or No, if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check Yes or No, if there is another health benefit plan. If yes, return to and complete items **9a-9d**.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable	Use this field when billing for a consultation or Healthy Connections participant. Enter the referring physician's name.
17a	Other ID	Required if applicable	Use this field when billing for consultations or HC participants. For consultations enter the qualifier **1D** followed by the referring physician's 9-digit Idaho Medicaid provider number. For Healthy Connections participants, enter the qualifier **1D** followed by the 9-digit Healthy Connections referral number. **Note**: The HC referral number is not required on Medicare crossover claims.
17b	NPI Number	Not Required	Enter the referring provider's 10-digit NPI number. **Note:** The NPI number, sent on paper claims, will not be used for claims processing.
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to four) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	If applicable, enter the PA number from Medicaid, DHW, RMS, ACCESS, RMHA, QIO, or MT.

24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). **Example:** November 24, 2003 becomes 11242003 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24C	EMG	Required if applicable	If the services performed are related to an emergency, mark this field with an **X**.
24D 1	Procedure Code Number	Required	Enter the appropriate five character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as four. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield **(1-4)** for the diagnosis code entered in field **21**.
24F	Charges	Required	Enter the usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H	EPSDT (Health Check) Screen	Required if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, see *Section 1.6 EPSDT*, for more information.
24I	ID. Qualifier	Required if Legacy ID	Enter qualifier **1D** followed by the 9-digit Idaho Medicaid provider number in **24J**.
24J	Rendering Provider ID Number	Required if applicable	Enter the 9-digit Idaho Medicaid provider number in the shaded portion of this field if the **1D** qualifier was entered in **24I**. **Note:** If the billing provider number is a group, then paper claims require the 9-digit Idaho Medicaid provider number of the performing provider in the Rendering Provider ID Number field. **Note:** Taxonomy codes and NPI numbers, sent on paper claims, will not be used for claims processing.
28	Total Charge	Required	The total charge entered should be equal to all of the charges for each detail line.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Include documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Balance due should be the difference between the total charges minus any amount entered in the amount paid field.
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See *Section 1.1.4 Signature-on-File Form* for more information.
33	Provider Name and Address	Required	Enter the name and address exactly as it appears on the provider enrollment acceptance letter or RA. **Note:** If you have had a change of address or ownership, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33A	NPI Number	Desired but not required	Enter the 10-digit NPI number of the billing provider. **Note:** NPI numbers, sent on paper claims are optional and will not be used for claims processing.

33B	Other ID	Required	Enter the qualifier **1D** followed by the provider's 9-digit Idaho Medicaid provider number. **Note:** All paper claims will require the 9-digit Idaho Medicaid provider number for successful claims processing.

3.5.3.4 Sample Paper Claim Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH. #

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS